



U.S. Pharmacopeia  
The Standard of Quality<sup>SM</sup>

## News Release

**FOR IMMEDIATE RELEASE**

**CONTACT:**

**Sherrie Borden**

301/816-8268; [slb@usp.org](mailto:slb@usp.org)

**Erin Gifford**

202/296-2002; [egifford@environics-usa.com](mailto:egifford@environics-usa.com)

### **USP Identifies Leading Medication Errors in Hospital Emergency Department *Tips Offered for Preventing Medication Errors in Fast-Paced, Urgent Care Situations***

**Rockville, Md., Mar. 12, 2003** – To mark National Patient Safety Awareness Week (Mar. 9–15), the United States Pharmacopeia (USP) today identified leading medication errors in hospital emergency departments (EDs) and offered tips for preventing errors in emergency situations.

USP created the recommendations after analyzing medication error data from its national databases containing more than 360,000 medication error reports since 1998. In 2001, hospitals reported more than 2,000 ED-related medication errors.

“Patients seen in the emergency department tend to be those most in need of urgent care. Timing is often critical and medications must be dispensed and administered quickly,” said Diane Cousins, R.Ph., vice president of USP’s Center for the Advancement of Patient Safety (CAPS). “In haste, however, medication errors can occur. To help prevent errors, consumers should take appropriate preventive measures, including keeping a current list of all medications they are taking and being aware of the most common emergency department errors.”

The combination of interruptions, intense pressure, and a fast-paced environment can lead to medication errors and fewer error interceptions in the ED. In fact, USP found that 23 percent of errors in the ED were detected before reaching patients as opposed to 39 percent detected in other areas of the hospital.

#### **Leading Medication Errors in the Emergency Department**

Upon analysis of drug errors submitted to MEDMARX, the anonymous national medication error reporting database, and USP’s Medication Errors Reporting Program\*, USP identified the following medication errors as those most frequently occurring in the emergency room:

- **Prescribing errors** – when a physician or other authorized prescriber fails to prescribe or authorize the correct medication through verbal or written communication;
- **Omission errors** – involves the failure to administer a prescribed medication; and
- **Improper dosage errors** – when a patient receives the incorrect dose of a medication.

~more~

## Tips for Preventing Medication Errors in Emergency Situations

While no one anticipates a visit to the ED, there are preventive measures that can be taken to help ensure that medication errors do not occur. With this in mind, USP offers the following tips for both patients and caregivers:

- Be sure to keep an up-to-date list of all medicines (prescription and over-the-counter) and dietary supplements that you are taking, including product names and strengths. On arrival at the hospital, provide the ED staff with this list to help minimize medication errors and prevent drug interactions.
- Make sure the ED doctors and nurses are aware of any allergies you may have. Inform them of drug names and associated allergic reactions. For life-threatening allergies, wear a MedicAlert bracelet at all times.
- To avoid duplicate dosing, be sure that you or your caregiver informs the nurse preparing to administer a possible second dose that you have already received the medication. If there is any question, always speak up to avoid an accidental overdose or duplicate dosage.
- Remember, “for a dose to be true divide pounds by 2.2.” Medications administered to children are often based on the child’s weight in kilograms. For purposes of preparing appropriate dosages of medicines, your child’s weight in pounds must be divided by 2.2 for conversion into kilograms. Be aware of this calculation and/or your child’s weight in kilograms, and reconfirm the correct dosage with the ED staff if you have concerns.
- Once released from the ED and/or hospital, be sure to make your primary care provider aware of any test results or necessary follow-up visits, as well as any medications administered while in the hospital.

In December 2002, USP released an analysis of medication errors captured in 2001 by MEDMARX, its anonymous, national reporting database. This third annual report, *Summary of Information Submitted to MEDMARX in the Year 2001: A Human Factors Approach to Medication Errors*, is the most comprehensive compilation of medication error data submitted by hospitals and health systems nationwide.

Of the 105,603 errors documented by MEDMARX, 2,063 errors, or 2 percent of total errors, occurred in the emergency room of a hospital or health care system. Although the majority of errors were corrected before causing harm to the patient, 147, or 7.6 percent of total errors, resulted in patient injury. Of this number, 123 resulted in temporary harm to the patient and required intervention, 21 required initial or prolonged hospitalization, one may have contributed to or resulted in permanent patient harm, one required intervention to sustain life, and one error resulted in a patient’s death.

For more information on MEDMARX, send an e-mail request to [mediarelations@usp.org](mailto:mediarelations@usp.org).

##

### USP—The Standard of Quality

USP is a non-government organization that promotes the public health by establishing state-of-the-art standards to ensure the quality of medicines and other health care technologies. These standards are developed by a unique process of public involvement and are recognized worldwide. In addition, USP has public health programs that focus on promoting optimal health care, including the Dietary Supplement Verification Program (DSVP), Health Care Information, and Patient Safety. USP is a not-for-profit organization that achieves its goals through the contributions of volunteers representing pharmacy, medicine, and other health care professions, as well as science, academia, government, the pharmaceutical industry, and consumer organizations. For more information, visit [www.usp.org/e-newsroom](http://www.usp.org/e-newsroom).

### CAPS – Improving Patient Safety by Preventing and Reducing Medication Errors.

The Center for the Advancement of Patient Safety (CAPS) was established to enhance USP’s work within the patient safety arena. Each year CAPS conducts an in-depth analysis and issues a report on medication errors by utilizing data captured from MEDMARX—the national, Internet-accessible, medication error prevention tool, which enables hospitals to anonymously report and track medication errors. In addition, CAPS seeks grants, develops professional education programs, publishes articles on issues related to medication errors, participates in legislative activities, and proposes standards, recommendations and guidelines to help improve patient safety and to ensure health quality by preventing and reducing medication errors.

\*USP’s Medication Errors Reporting Program is operated in conjunction with the Institute for Safe Medication Practices (ISMP).